4400-ADV (5-2005)
Supersedes (4-2005) issue

Sandia National Laboratories

Application for Sandia's Dental & Vision Plans

☐ Initial Enrollment ☐ Reinstatement from Leave of Absence ☐ Additions/Changes

A) Primary Member Information

Name (Last, First, MI): _____ SSN: _____ Union: _____

Gender: _____ DOB: _____ Hire Date: _____ Bus. Phone: _____ Home Phone: _____

B) Enrollment Information

Type of coverage:

☐ Dental
- ☐ Single
- ☐ Family*
- ☐ Decline coverage
- ☐ Dependent of another Sandian**

☐ Vision
- ☐ Single
- ☐ Family*
- ☐ Decline coverage
- ☐ Dependent of another Sandian**

*If you checked Family, please list your dependents below.
**If you are a dependent under another Sandian's dental and/or vision plan(s), please enter their name and SSN here: Name: _____ SSN: _____

Dependents to be insured:
Dependents eligibility requirements are detailed in the applicable Summary Plan Descriptions.

					FOR BENEFITS USE ONLY	
Dependent(s) Name(s)	Relationship to Employee***	Gender	Birth Date	Social Security #	Effective Date	Cancel Date

Reason for enrollment (e.g., new hire, marriage, new baby, etc.) _____

Dental & Vision coverage effective date: _____

C) Sign below to authorize the enrollment of the above dependent(s) in your dental and/or vision coverage.

_____ _____
Employee Signature Date

Note: This form must be received by the Benefits Customer Service Center within 31 days of the mid-year election change event if your premiums are deducted on a pre-tax basis.

Fax this form to 505-844-7535 or mail to:
Sandia National Laboratories
Attn: Benefits Customer Service
PO Box 5800 MS 1022
Albuquerque, NM 87185-1022

For Benefits Use Only:

_____ _____
Signature of Benefits representative entering change Date change entered in SNL database: